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Office of Administrative Law Judges
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Issue Date: 28 July 2003

Case No: 2002-BLA-5341

In the Matter of

LARRY S. BOGGS,
Claimant

v.

MINGO LOGAN COAL CO.,
Employer,

ARCH COAL INC.,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

William L. Roberts, Esquire
For the claimant

Matin E. Hall, Esquire
For the employer/carrier

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER — DENYING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (the Act). Benefits are

awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201(a) (2001).

On July 24, 2002, this case was referred to the Office of Administrative Law Judges for a formal hearing. (DX 40). Following proper notice to all parties, a hearing was held on February 12, 2003 in Prestonsburg, Kentucky. The Director's exhibits were admitted into evidence pursuant to 20 C.F.R. § 725.456, and the parties had full opportunity to submit additional evidence and to present closing arguments or post-hearing briefs.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They also are based upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to DX, CX, and EX refer to the exhibits of the Director, claimant, and employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUES

The following issues remain for resolution:

1. whether the miner has pneumoconiosis as defined by the Act and regulations;

2. whether the miner's pneumoconiosis arose out of coal mine employment;

3. whether the miner is totally disabled; and

4. whether the miner's disability is due to pneumoconiosis.

The employer also contests other issues, such as the numerical restrictions placed upon evidentiary submissions adopted in the amended regulations. (Tr. 8). These issues are beyond the authority of an administrative law judge and are preserved for appeal.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

The claimant, Larry Boggs, was born on September 27, 1950. (DX 2). Mr. Boggs married Freda Cornett on December 11, 1971, and they reside together. (DX 10; Tr. 12). They had no children who were under eighteen or dependent upon them at this time this claim was filed. (DX 2; Tr. 12). Mr. Boggs has his G.E.D. (DX 2).

Claimant testified that he easily becomes short of breath. (Tr. 15). He stated that walking over 100 yards or climbing one flight of stairs exhausts him. (Tr. 15). He can no longer perform domestic chores around the house such as mowing, gardening, or repair his car. (DX 5). His wife and children take care of the shopping and household chores. (DX 5). He also no longer hunts or fishes if he is required to walk. (DX 5).

According to Claimant, his shortness of breath forced him to leave his coal mining job. (Tr. 14-15; DX 4). Claimant testified that he has been hospitalized more than fifteen times over the past three to four years for breathing problems. (Tr. 20). Claimant has treated with Dr. Abad for his breathing problems for over three years. (Tr. 15).

Beyond his breathing problems, Claimant has numerous other physical ailments. He is currently on Social Security total disability compensation due to a heart condition, (Tr. 17-18). He has an irregular heart beat and has undergone a heart catheterization procedure. (Tr. 18). He also suffers from arthritis and smothering when he bends over. (DX 5). He currently takes prescription medication for his heart problems, high blood pressure, nerves and anxiety. (Tr. 18-19). He uses supplemental oxygen and a nebulizer to aid his breathing. (Tr. 22-23).

Claimant testified that he has smoked intermittently since he was sixteen or seventeen years old. (Tr. 19). He estimated that he had smoked one-half to one pack of cigarettes per day for a total of twenty-five years. (Tr. 19).

Mr. Boggs filed his application for black lung benefits on January 31, 2001. (DX 2). The Office of Workers' Compensation Programs issued a proposed denial of benefits on April 2, 2002. (DX 33). Pursuant to Claimant's request for a formal hearing, (DX 35), the case was transferred to the Office of Administrative Law Judges. (DX 40).

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. Claimant bears the burden of proof in establishing the length of his coal mine work. *See Shelesky v. Director, OWCP*, 7 BLR 1-34, 1-36 (1984); *Rennie v. U.S. Steel Corp.*, 1 BLR 1-859, 1-862 (1978). On his application for benefits, Mr. Boggs

alleged twenty-four years of coal mine employment. Employer does not challenge Claimant's allegation of coal mine employment. (DX 40). I find the Social Security records supportive of Claimant's allegation, and I credit him with twenty-four years of coal mine employment. (DX 3, 7).

Claimant worked a variety of jobs during his coal mining career, including belt man, car driver, and miner operator. (Tr. 13). All of his coal mine employment was worked underground. (Tr. 13). Claimant's last coal mining job was as a long wall miner. (DX 2). He was required to lift heavy objects (occasionally in excess of 100 pounds), bend, stoop, push, and pull in the performance of his job. (Tr. 13-14). Cutting and welding were also required to work on the long wall. (DX 4). He testified that the work was extremely dusty, blowing into his eyes, nose, and throat. (Tr. 14; DX 2). The dust caused him to cough on a daily basis. (Tr. 14). As a long wall miner, he worked five ten-hour shifts per week. (DX 4). He was required to maintain all of the equipment and run the coal after maintenance work was completed. (DX 4). Claimant estimated that he was required to stand nine hours per day and sit one hour per day in the performance of his job. (DX 4).

I find Claimant's coal mine employment involved moderate to heavy manual labor. The record and Claimant's testimony demonstrate that he worked in a dusty, underground environment where he was required to work on his feet (bending, stooping, pushing, and pulling) for a substantial amount of the time. In addition, he was required to lift heavy objects and cut and weld materials. Claimant's testimony paints a picture of a difficult work environment, and no evidence of record contradicts his testimony and written allegations concerning his employment.

Medical Evidence

Medical evidence submitted under a claim for benefits under the Act is subject to two different requirements. First, medical evidence must be in "substantial compliance" with the applicable regulations' criteria for the development of medical evidence. *See* 20 C.F.R. §718.101 to 718.107. The regulations address the criteria for chest x-rays, pulmonary function tests, physician reports, arterial blood gas studies, autopsies, biopsies, and "other medical evidence." *Id.* "Substantial compliance" with the applicable regulations entitles medical evidence to probative weight as valid evidence.

Secondly, medical evidence must comply with the limitations placed upon the development of medical evidence. 20 C.F.R. §725.414. The regulations provide that claimants are limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act. §725.414(a)(2)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports, and physician opinions that appear in one single medical report must comply individually with the evidentiary limitations. *Id.* In rebuttal to evidence propounded by an

opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, biopsy, or autopsy. §725.414(a)(2)(ii).[1] Likewise, responsible operators and the district director are subject to identical limitations on affirmative and rebuttal evidence. §725.414(a)(3)(i, iii).[2]

Both parties have submitted their evidentiary selection forms. (CX 3, EX 18). I will consider only the evidence selected by the parties to comply with the numerical limitations found in the regulations. I will not consider any other evidence proffered by the parties in the record.

Applying the regulations to Employer's selected evidence, several problems arise. First, Employer selected x-ray interpretations from Drs. Wiot and Wheeler to fill Employer's allotment of two x-ray interpretations under section 725.414(a)(3)(i). Employer's narrative medical reports – produced by Drs. Dahhan and Hippensteel - however, also contain x-ray interpretations. Section 725.414(a)(3)(i) provides, "Any chest x-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, and physicians' opinions that appear in a medical report *must each be admissible under this paragraph or paragraph (a)(4) of this section*." 20 C.F.R. §725.414(a)(3)(i) (emphasis added). The x-ray interpretations in the opinions of Drs. Dahhan and Hippensteel are not admissible on their own as they exceed the numerical restriction of two, non-rebuttal x-ray interpretations per party. 20 C.F.R. §725.414(a)(2, 3)(i). If I considered the x-ray interpretations of Drs. Dahhan and Hippensteel, Employer would have four x-ray interpretations in the record.

The regulations do not specifically address the effect on a physician's narrative opinion when he or she includes and considers impermissible evidence. If I were to exclude the opinions altogether, Employer would be stripped of all its selected evidence except for the two x-ray interpretations proffered by Drs. Wiot and Wheeler. Conversely, considering the opinions from Drs. Dahhan and Hippensteel exclusive of their x-ray interpretations is equally troubling because it is impossible to determine the extent to which their opinions regarding pneumoconiosis and total disability and causation are influenced by their x-ray interpretations. In the interest of fairness to all parties, I shall retain the x-ray interpretations proffered by Drs. Dahhan and Hippensteel, and I shall exclude the x-ray interpretations of Drs. Wiot and Wheeler. My decision limits Employer to two x-ray interpretations, thus ensuring a level playing field with Claimant, while simultaneously avoiding the consequence of stripping the majority of Employer's evidence away. In the absence of regulatory or statutory guidance, I find this solution most equitable.

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[1] Rebuttal evidence is indicated in the chart below by "R-" prefix before the exhibit number, such as R-DX2 or R-EX4.

[2] If no responsible operator has been named, the evidence obtained in connection with the complete pulmonary evaluation performed pursuant to §725.406 shall be considered evidence obtained and submitted by the Director.

Dr. Hippensteel's opinion suffers from another malady. In his opinion, the doctor reviews evidence not contained within the record such as x-ray interpretations from Drs. Wiot and Barrit. Again, section 725.414(a)(3)(i) provides, "Any chest x-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, and physicians' opinions that appear in a medical report *must each be admissible under this paragraph or paragraph (a)(4) of this section*." 20 C.F.R. § 725.414(a)(3)(i) (emphasis added). As the doctor's report contains inadmissible evidence it cannot be fully considered. Dr. Hippensteel's opinion is divided between his examination opinion and medical review opinion. (EX 12, p. 4). Accordingly, I shall only consider the doctor's examination opinion, and I shall not consider his medical review opinion which contains inadmissible evidence.

Dr. Dahhan's January 13, 2003 deposition transcript is also part of the record. The doctor's deposition testimony addresses, in part, medical evidence not in the record. Specifically, he testifies concerning two supplemental reports he prepared on December 10, 2002 and January 8, 2003, respectively. (Dahhan Depo., p. 10). The supplemental reports address chest x-rays, electrocardiogram reports, hospital admission reports, hospital discharge reports, an arterial doppler study, an echocardiogram, and physicians' opinions, most of which are not admitted in the record. Section 725.458 provides that the "testimony of any physician which is taken by deposition shall be subject to the limitations on the scope of testimony contained in § 725.457 (d)." 20 C.F.R. § 725.458. In turn, section 725.457(d) provides: "A physician...may testify as to any other medical evidence of record, but shall not be permitted to testify as to any medical evidence relevant to the miner's condition that is not admissible." 20 C.F.R. §725.457(d). As Dr. Dahhan's supplemental reports are not admissible, he cannot testify regarding them or the medical evidence they review. Accordingly, I cannot consider the doctor's deposition.

A. X-ray reports[3]

Exhibit	Offering Party	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 12	Employer	04/21/01	04/21/01	Dahhan	Completely negative
DX 14	DOL exam	05/08/01	05/21/01	Patel	0/1 profusion. "Consistent with pneumoconiosis."

[3] A chest x-ray may indicate the presence or absence of pneumoconiosis. 20 C.F.R. §718.102(a,b). It is not utilized to determine whether the miner is totally disabled, unless complicated pneumoconiosis is indicated wherein the miner may be presumed to be totally disabled due to the disease.

Exhibit	Offering Party	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
R-DX 16	Employer	05/08/01	12/14/01	Wiot/B[4]/BCR[5]	Completely negative
DX 14		05/08/01		Sargent	Film quality review only. Film quality = 2.
EX 12	Employer	12/17/02	12/17/02	Hippensteel	Completely Negative

[4] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2). Interpretations by a physician who is a "B" reader and is certified by the American Board of Radiology may be given greater evidentiary weight than an interpretation by any other reader. *See Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (Mar. 23, 1995)(unpublished). When evaluating interpretations of miners' chest x-rays, an administrative law judge may assign greater evidentiary weight to readings of physicians with superior qualifications. 20 C.F.R. § 718.202(a)(1); *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211, 1-213 (1985). The Benefits Review Board and the United States Court of Appeals for the Sixth Circuit have approved attributing more weight to interpretations of "B" readers because of their expertise in x-ray classification. *See Warmus v. Pittsburgh & Midway Coal Mining Co.*, 839 F.2d 257, 261 n.4 (6th Cir. 1988); *Meadows v. Westmoreland Coal Co.*, 6 BLR 1-773, 1-776 (1984). The Board has held that it is also proper to credit the interpretation of a dually qualified physician over the interpretation of a B-reader. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). *See also Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985) (weighing evidence under Part 718).

[5] Board-certified radiologist

B. Pulmonary Function Studies[6]

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Tracings	Comments
DX 14 05/08/01	Rasmussen	50 67’	2.68	3.71	85		Yes	Good cooperation and comprehension. Minimal obstructive ventilatory impairment. Maximum breathing capacity is reduced.
DX 12 04/21/01	Dahhan	50 65’	1.23 1.88*	1.76 2.40*			Yes	Poor cooperation and good comprehension
EX 12 12/17/02	Hippensteel	52 68’	2.06 2.20*	3.13 3.35*	57	0.66 0.66*	Yes	Mild airflow obstruction post-bronchodilator. MVV is severely reduced with grossly variable total volumes. Lung volumes are normal. Diffusion is normal. Poor effort.

*denotes testing after administration of bronchodilator

[6] The pulmonary function study, also referred to as a ventilatory study or spirometry, indicates the presence or absence of a respiratory or pulmonary impairment. 20 C.F.R. § 718.104 (c) . The regulations require that this study be conducted three times to assess whether the miner exerted optimal effort among trials, but the Board has held that a ventilatory study which is accompanied by only two tracings is in “substantial compliance” with the quality standards at § 718.204(c)(1). *Defore v. Alabama By-Products Corp.*, 12 B.L.R. 1-27 (1988). The values from the FEV1 as well as the MVV or FVC must be in the record, and the highest values from the trials are used to determine the level of the miner's disability.

C. Arterial Blood Gas Studies[7]

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise	Comments
DX 12	04/21/01	Dahhan	43.4 41.7	77.3 85.5	Resting Exercise	Exercise terminated due to fatigue.
DX 14	05/08/01	Rasmussen	52 46	60 66	Resting Exercise	Minimal resting hypoxia and hypercarbia. Minimal hypoxia with exercise
EX 12	12/17/02	Hippensteel	49.6	64.3		Mild hypoxemia referable to hypoventilation with a normal alveolar-arterial oxygen gradient.
CX 1	01/02/03	Williamson Appalachian Regional Hospital	39.2	68.0	Resting	

On August 7, 2001, Dr. N. K. Burki issued a validation study of Claimant's May 8, 2001 arterial blood gas study. (CX 14). Dr. Burki opined that the results were technically acceptable.

D. Narrative Medical Evidence

Dr. Abdul Dahhan administered a complete pulmonary examination of Claimant on April 21, 2001, including a physical examination, chest x-ray, pulmonary function test, arterial blood gas study, electrocardiogram, and a carboxyhemoglobin level test. (DX 12). In his report, Dr. Dahhan noted that Claimant presented 1) twenty-seven years of coal mine employment as a maintenance worker and 2) thirty-four years of cigarette smoking ranging from one-half to one pack per day. During his examination, Claimant complained of daily cough with sputum production, frequent wheeze, sleep apnea, hypertension, frequent edema, and dyspnea upon exertion

[7] Blood-gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. 20 C.F.R. §718.105(a).

such as climbing one-half flight of stairs. Dr. Dahhan observed the following during his physical examination of Claimant: 1) multiple arm and hip injuries; 2) removal of the left salivary gland; 3) good air entry to both lungs with no crepitation or wheeze; and 4) regular cardiac rhythm with normal heart sounds, no gallops or murmurs detected. The doctor also reported that the electrocardiogram results were normal, carboxyhemoglobin level indicated an individual smoking one pack of cigarettes per day, arterial blood gas study results normal, and chest x-ray films negative for pneumoconiosis. Dr. Dahhan reported the figures obtained from Claimant's pulmonary function test results, but he did not comment on them in the body of his report. After his examination and review of the objective test results, the doctor opined the following: 1) there is insufficient objective data exists to justify a diagnosis of pneumoconiosis based upon Claimant's normal chest examination, normal blood gas results, negative chest x-ray, and pulmonary function abnormalities arising from other causes; 2) Claimant suffers from an obstructive airways disease based upon his pulmonary function test results and sleep apnea; 3) Claimant does not retain the respiratory capacity to return to his previous coal mining work or job of comparable physical demand because of his obstructive airways disease and sleep apnea; and 4) Claimant's chronic obstructive lung disease has resulted from his lengthy smoking habit, which he continues to indulge as demonstrated by the elevated carboxyhemoglobin level value, and sleep apnea. Dr. Dahhan also diagnosed hypertension, anxiety with depression, hay fever, and arthritis, but he stated that each was a condition of the general public and not related to coal dust inhalation.

Dr. D. L. Rasmussen administered a complete pulmonary examination of Claimant on May 8, 2001, consisting of a physical examination, chest x-ray, pulmonary function test, arterial blood gas, and a single breath carbon monoxide diffusion capacity test. (DX 14). In his report, Dr. Rasmussen noted Claimant's employment, military, family, social, and medical histories. He specifically noted that Claimant served in the Army in Korea and Vietnam from 1968 to 1971, and worked a variety of jobs in the coal mining industry over a twenty-seven year period, including belt man, shuttle car operator, continuous miner operator, and long wall miner. Claimant informed the doctor that his long wall mining job required heavy lifting, use of heavy tools, occasional shoveling, and walking up and down a 1000 foot space. The doctor recorded that Claimant has a family history of high blood pressure, heart disease, asthma, allergies, stroke, and emphysema, while Claimant himself reported a medical history of frequent colds, pneumonia, pleurisy, wheezing attacks, chronic bronchitis, arthritis, heart disease, allergies, and high blood pressure. Claimant also relayed several surgical procedures he had undergone, including salivary gland surgery in the 1980s, right arm surgery in 1994, left elbow surgery in 1999, and left shoulder surgery in 2000. Claimant also informed the doctor he had been hospitalized two additional times for syncope with tachycardia in 1992 and an abscess in right hip in 1998. Dr. Rasmussen also included in his report that Claimant had smoked three-quarters of one pack of cigarettes per day since 1968 and occasionally drank alcohol. During the physical examination, Claimant complained of the following symptoms: daily sputum production; constant wheezing aggravated by perfumes, hair spray, and gas fumes; dyspnea for the past five years after climbing one flight of stairs; cough; hemoptysis with colds; chest pain; orthopnea requiring one pillow for comfort; sleeplessness; dizziness; back pain radiating to his knees and right ankle; ankle edema for the past two years; and paroxysmal nocturnal dyspnea. Dr. Rasmussen cataloged Claimant's current

medications in his report. During his examination, the doctor noted minimally reduced breath sounds, increased expiratory phase, and mild wheeze with forced expiration. The doctor recorded the following results from his objective testing: 1) chest x-ray reveals 0/1 profusion, s/s in mid- to lower zones, and pleural thickening; 2) pulmonary function test results demonstrate minimal obstructive ventilatory impairment; 3) arterial blood gas study results reveal minimal resting hypoxia and hypercarbia and minimal hypoxia with exercise; and 4) single breath carbon monoxide diffusion capacity test results minimally reduced. Dr. Rasmussen diagnosed 1) chronic obstructive pulmonary disease/emphysema based upon Claimant's airflow obstruction and reduced single breath carbon monoxide diffusion capacity; 2) history of paroxysmal tachycardia; and 3) possible sleep apnea based upon history. Dr. Rasmussen attributed Claimant's chronic obstructive pulmonary disease/emphysema to Claimant's coal dust exposure and cigarette smoking. Addressing Claimant's pulmonary function, the doctor stated, "The patient has at least [a] minimal loss of lung function. He does not retain the pulmonary capacity to perform his last regular coal mine job. The two risk factors are his cigarette smoking and his coal mine dust exposure." *Id.* The doctor opined that Claimant respiratory problems produced a moderate impairment.

Dr. Kirk E. Hippensteel administered a pulmonary examination of the claimant on December 17, 2002, including a physical examination, chest x-ray, pulmonary function test, and arterial blood gas study. (EX 12). In his report, Dr. Hippensteel discussed Claimant's medical, employment, and social histories, specifically noting Claimant's alleged twenty-seven years of underground coal mine employment as a long wall miner, shuttle car operator, mechanic, and belt man. Claimant reported to Dr. Hippensteel breathing problems since 1988, including current symptoms of exhaustion upon walking only 100 feet or climbing less than one flight of stairs, coughing, sputum production, and seasonal allergies. The doctor also noted that Claimant is a smoker - smoking one-half to one pack of cigarettes per day for approximately twenty to twenty-five years total. On physical examination, Dr. Hippensteel observed that Claimant's lungs "have minimal wheezes, scattered bilaterally with no rales audible and reasonably good air measurement." (EX 12). Dr. Hippensteel cataloged the results of Claimant's objective testing, finding the following: 1) Claimant's x-ray is negative for pneumoconiosis; 2) Claimant's pulmonary function test results suggest obstructive disease that is mild in degree post-bronchodilator, results suggest suboptimal effort, and his lung volumes show normal values for functional residual capacity and total lung capacity indicative of no restriction, diffusion is normal; 3) arterial blood gas study results demonstrate mild hypoxemia, and carboxyhemoglobin level is elevated to levels consistent with smoking greater than two packs per day rather than the half pack per day that Claimant reports. After his examination and objective testing, the doctor opined that Claimant did not suffer from pneumoconiosis. He diagnosed Claimant as suffering from a mild obstructive pulmonary impairment, and he concluded that Claimant is physically unable to return to coal mining, although he stated that, from a respiratory standpoint, he could continue to work in the coal mines. He stated that other risk factors contributed to Claimant's breathing symptoms such as smoking, seasonal allergies, sleep apnea aggravated by obesity, and medication that obstructs airflow. Dr. Hippensteel also opined that Claimant's dyspnea was caused by back and leg pain and not breathlessness.

On January 16, 2003, Dr. Augusto Abad issued a medical report. (CX 2). The report is one page in length, and it does not contain any objective test results. In his report, Dr. Abad opined that Claimant suffered from clinical and legal pneumoconiosis due to an obstructive and restrictive airway disease. The doctor also concluded that Claimant was totally disabled from coal mine employment based upon Claimant's "persistent bronchospasms and hypoxemia." The etiology of Claimant's pulmonary impairment was a combination of pneumoconiosis and smoking, according to the doctor.

E. Other Medical Evidence

The amended regulations provide that, notwithstanding the evidentiary limitations contained at 20 C.F.R. §725.414(a)(2) and (a)(3), any record of a miner's hospitalization for respiratory or pulmonary or related disease may be received into evidence. 20 C.F.R. §725.414(a)(4). Furthermore, a party may submit "other medical evidence" reported by a physician and not specifically addressed under the regulations under section 718.107, such as a CT scan.

On June 21, 2002, Dr. Bapuji Narra issued a CT scan report concerning Claimant's chest. (EX 11). Dr. Narra reported that his review of the scan reveal no abnormal findings but only a normal chest scan.

Pursuant to section 725.414(a)(4), Employer has introduced various hospital records into the record. (EX 2-3, 5-7). The records include x-rays, surgical procedure notes, echocardiogram reports, consultation reports, operation reports, and examination reports. In my review of the hospital evidence, I have identified the following relevant pieces of medical evidence:

> 1) August 9, 2001 radiology report by Dr. Robert Santee - Interpreted chest x-ray as normal. The doctor did not offer an opinion on the presence of pneumoconiosis.
>
> 2) December 3, 2000 radiology report by Dr. Joseph Dransfield - Interpreted chest x-ray as normal. The doctor did not offer an opinion on the presence of pneumoconiosis.
>
> 3) May 31, 2002 radiology report by Dr. Peter Chirico - Interpreted chest x-ray as normal. The doctor did not offer an opinion on the presence of pneumoconiosis.
>
> 4) March 15, 2002 report by Dr. Naveed Ahmed - In his visit with Dr. Ahmed, Claimant complained of elbow, back, and leg pain. However, Dr. Ahmed reported that Claimant "denied any shortness of breath, chest pain, or palpitations and no GI symptoms." Upon physical examination, Dr. Ahmed reported normal breath sounds.

5) February 26, 2002 examination by Dr. Sree Karanam in which Dr. Karanam noted that Claimant's lungs were "clear to auscultation."

6) April 1, 2002 consultation report of Dr. George Cortas noting that, upon examination, Claimant exhibited no wheezes, rhonchi, or rales.

7) May 2, 2002 examination report of Dr. Ahmed, again noting normal breath sounds.

8) June 4, 2002 examination report of Dr. Cortas, again noting no wheezes, rhonchi, or rales upon examination.

9) December 1, 2000 radiology report of Dr. Donald Lewis - Interpreted x-ray as normal. Stated, "Lungs are clear of active disease."

10) June 25, 2001, July 30, 2001, October 31, 2001, and November 9, 2001 examination notes from Dr. S. A. Vyas in which doctor notes Claimant's lungs "clear to percussion and auscultation."

and

11) June 2, 1998 radiology report of Dr. A. Hashem interpreting chest x-ray film as normal. The doctor did not offer a specific opinion on the presence of pneumoconiosis.

Medical evidence submitted by Claimant also includes medical records from Appalachian Regional Healthcare, Inc. (CX 1). Included in the records is an admission examination performed by Dr. Abad. Claimant came to the hospital complaining of chest pain and shortness of breath. Dr. Abad took Claimant's medical and surgical histories, noting Claimant had a history of chronic obstructive pulmonary disease, hypertension, anxiety, depression, tachyarrhythmia, coronary artery disease, diabetes mellitus, elbow surgeries, left hip surgery, neck surgery, and kidney stones. Commenting on Claimant's present symptoms, Dr. Abad noted that Claimant had been treated for chest pain and shortness of breath five days earlier and, then, released. Claimant stated that his conditions were getting worse, and Dr. Abad observed diffuse and audible wheezing. Upon admittance and examination, Dr. Abad noted that Claimant was a smoker and, according to his wife, had been drinking lately. Dr. Abad observed that Claimant's lungs presented inspiratory and expiratory wheezes, and bibasilar crepitations. The doctor's admitting impressions were: chest pain syndrome, accelerated hypertension, acute exacerbation of chronic obstructive pulmonary disease, acute bronchitis, and anxiety reaction.

DISCUSSION AND APPLICABLE LAW

Because Claimant filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Under this part of the regulations, claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989).

Pneumoconiosis and Causation

The new regulatory provisions at 20 C.F.R. § 718.201 contain a modified definition of "pneumoconiosis" and they provide the following:

(a) For the purposes of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis.

(1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (Dec. 20, 2000). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Each shall be addressed in turn.

Under section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP*, 12 BLR 1-6 (1988); *Clark*, 12 BLR 1-149 (1989).

The record contains four interpretations of three chest x-rays. Each interpretation was negative for pneumoconiosis. Because the negative readings constitute all of the interpretations of record, I find the x-ray evidence is negative for pneumoconiosis.

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy or autopsy evidence. This section is inapplicable herein because the record contains no such evidence.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions applies to this claim, claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides the fourth and final way for a claimant to prove that he has pneumoconiosis. Under section 718.202(a)(4), a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. Although the x-ray evidence is negative for pneumoconiosis, a physician's reasoned opinion may support the presence of the disease if it is supported by adequate rationale besides a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 1-22, 1-24 (1986). The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions.

A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 BLR 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms and patient's history.

See Hoffman v. B & G Construction Co., 8 BLR 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 BLR 1-295 (1984); *Buffalo v. Director*, OWCP, 6 BLR 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp*., 2 BLR 1-130 (1979).

A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for this Court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d 982 (8th Cir. 1985); *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.*, 4 B.L.R. 1-601 (1982).

The record in the instant case contains four physicians' opinions addressing Claimant's respiratory health. Three physicians – Drs. Dahhan, Abad and Rasmussen – opine that Claimant suffers from pneumoconiosis, while the remaining physician – Dr. Hippensteel – concludes that Claimant does not suffer from pneumoconiosis. Each opinion shall be discussed and weighed individually. In addition to the medical reports of record, I shall discuss and weigh the CT scan evidence and hospital records evidence under this section.

I find Dr. Dahhan's opinion to be well documented and well reasoned. The doctor provides a clear diagnosis of no coal workers' pneumoconiosis, and he provides explicit bases for his opinion. Hence, I find his opinion entitled to probative weight. Dr. Dahhan opined that Claimant suffers from a chronic obstructive lung disease, however, based upon Claimant's pulmonary function test results. The definition of "legal pneumoconiosis" specifically "includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." 20 C.F.R. § 718.201(a)(2). Thus, I find the doctor's opinion satisfies the disease component of legal pneumoconiosis, if not the causation component.

I find Dr. Rasmussen's opinion to be well reasoned and well documented. The doctor's report is extremely thorough, detailing Claimant's medical and family histories and the doctor's examination observations with unusual and probative depth. Dr. Rasmussen diagnosed Claimant as suffering from chronic obstructive pulmonary disease and emphysema based upon Claimant's airflow obstruction and reduced diffusion capacity. Thus, the doctor's opinion diagnoses the presence of legal pneumoconiosis. 20 C.F.R. § 718.201(a)(2). The doctor's diagnosis is clear, and his rationale is supported by the documented evidence in his report. Accordingly, I grant his opinion probative weight.

Dr. Hippensteel opined that Claimant suffered from a "mild obstructive pulmonary impairment," but he did not suffer from coal workers' pneumoconiosis or any disease arising out of coal mine employment. I find that the doctor's opinion is well documented but it is poorly

reasoned. Dr. Hippensteel opines that Claimant suffers from a mild obstructive pulmonary impairment attributable to smoking, seasonal allergies, sleep apnea, and medications but not coal dust inhalation. The doctor fails, however, to explain how he arrived at that conclusion. The doctor provides absolutely no guidance on how he discerned that Claimant's pulmonary condition is the byproduct of certain, other risk factors *but not* coal dust inhalation. Furthermore, Dr. Hippensteel cites problems with both Claimant's pulmonary function test and arterial blood gas study. As he never cites his physical examination as informing his pneumoconiosis diagnosis, it is unclear what valid, probative medical evidence he relied upon in forming his, admittedly vague, medical conclusions. Thus, I find his opinion is poorly reasoned, and I grant his opinion less weight.

Dr. Abad's opinion is poorly documented and poorly reasoned. I grant it little probative value. Beyond a reference to an examination is the first pre-printed question in the doctor's form opinion, it is unclear what, if any, medical testing the doctor administered on Claimant. Secondly, the doctor provides no bases for his opinion, instead the doctor confusingly lists a diagnosis – obstructive and restrictive airway disease – as a basis for his diagnosis. I grant the one-page opinion, consisting of twenty some odd, barely legible words, little to no probative weight.

Dr. Narra's CT scan report is well documented. I grant his finding of no abnormalities probative weight, although, as the report is inherently less comprehensive than an examination report, the weight I grant the CT scan is somewhat reduced.

Considering the hospital records as a whole, I find they are not supportive of a finding of pneumoconiosis. I find most probative the numerous physical examination observations by numerous physicians of "clear" and "normal" lung sounds without crepitation, rales, or rhonchi as opposed to the singular observations of Dr. Abad of wheezing and crepitation. As the hospital materials were not intentioned for pneumoconiosis diagnosis, I do grant them less probative weight, however.

I find the narrative reports as a whole do not establish *clinical* pneumoconiosis by a preponderance of the evidence. Only Dr. Abad opines that Claimant suffers from clinical pneumoconiosis, and I have found Dr. Abad's opinion entitled to little to no probative weight. The remaining narrative evidence provides no support for a finding of clinical pneumoconiosis.

Conversely, I find the narrative evidence establishes the presence of *legal* pneumoconiosis. Drs. Dahhan and Rasmussen provide well reasoned, probative opinions, with Dr. Rasmussen's opinion garnering slightly more weight. Both physicians diagnosed the presence of chronic obstructive pulmonary disease. The probative weight I accord the opinions of Drs. Hippensteel and Abad is less than the other two narrative opinions, and I find that Dr. Hippensteel's opinion, with its flaws, is entitled to more probative weight than Dr. Abad's opinion. Dr. Hippensteel diagnosed an obstructive pulmonary defect, but he did not opine that the

defect was chronic. Accordingly, I do not interpret his opinions as supportive of legal pneumoconiosis. Yet, when I consider the four narrative opinions as a whole, I find the combined weight of the opinions of Drs. Dahhan and Rasmussen, along with the minimal weight I assign to Dr. Abad's opinion, outweigh Dr. Hippensteel's opinion. Accordingly, I find Claimant has established the presence of legal pneumoconiosis.

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a).

Because Claimant has established over ten years of coal mine employment, he is entitled to a rebuttable presumption that his pneumoconiosis arose from coal mine employment. *See* 20 C.F.R. § 718.203(b). This presumption may be rebutted by evidence demonstrating another cause for claimant's pneumoconiosis.

As Drs. Dahhan and Rasmussen were the lone physicians to diagnose legal pneumoconiosis, their opinions on causation are the only relevant opinions in the causation inquiry. *Cf. Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819 (4th Cir. 1995)(finding opinions not diagnosing pneumoconiosis less probative of whether total disability due to pneumoconiosis); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995).

I grant the causation opinion of Dr. Dahhan reduced probative weight because of the doctor's insufficiently explained rationale. Dr. Dahhan based his diagnosis of chronic obstructive lung disease on Claimant's pulmonary function test results. He opined that Claimant's chronic obstructive lung disease was caused by Claimant's "lengthy smoking habit," citing Claimant's elevated carboxyhemoglobin level. Beyond citing an elevated carboxyhemoglobin level, however, Dr. Dahhan fails to explain why Claimant's chronic obstructive lung disease was caused by cigarette smoking and not coal dust inhalation. The doctor points to no evidence demonstrating effects caused by cigarette smoking but not coal dust inhalation, nor does he provide a distinction between the types of diseases and their severity caused by cigarette smoking as opposed to coal dust inhalation. In fact, Dr. Dahhan never discusses the possibility that Claimant's pulmonary problems have been contributed to by his years of coal dust inhalation. For these reasons, I grant the doctor's causation opinion less weight.

Dr. Rasmussen opined that Claimant's pulmonary condition was attributable to coal dust inhalation and cigarette smoking. Despite the doctor's evident consideration of both smoking and coal dust inhalation as causal factors for pulmonary disease, the doctor's opinion is as light on reasoning as Dr. Dahhan's opinion. He provides no rationale for attributing Claimant's pulmonary condition to those two factors. Accordingly, I grant the doctor's opinion less weight.

I find that the record contains insufficient evidence to rebut the presumption that Claimant's legal pneumoconiosis was caused, at least in part, by coal dust inhalation. Only Dr. Dahhan's

opinion attributes Claimant's legal pneumoconiosis to cigarette smoking solely, and, as I have found his opinion to be poorly reasoned on this point, I find the presumption has not been rebutted. Accordingly, Claimant has demonstrated legal pneumoconiosis arising out of coal mine employment.

In sum, the evidence establishes that Claimant has pneumoconiosis and that his pneumoconiosis arose out of coal mine employment. In order to establish entitlement to benefits, however, the evidence also must establish that claimant is totally disabled due to pneumoconiosis.

Total Disability Due to Pneumoconiosis

A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204 (b)(1). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 BLR 1-11, 1-15 (1991). Section 718.204(b)(2) provides several criteria for establishing total disability. Under this section, I must first evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike evidence, to determine whether claimant has established total respiratory disability by a preponderance of the evidence. *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195, 1-198 (1987).

Under Sections 718.204(b)(2)(i) and (b)(2)(ii), total disability may be established with qualifying pulmonary function tests or arterial blood gas studies.[8]

In the pulmonary function studies of record, there is a discrepancy in the height attributed to the claimant. The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1- 221 (1983). *See also Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995). In determining the validity and probativeness of the pulmonary function tests of record, I shall utilize the average height reported for Claimant, or 66.67 inches.

All ventilatory studies of record, both pre-bronchodilator and post- bronchodilator, must be weighed. *Strako v. Ziegler Coal Co.*, 3 B.L.R. 1-136 (1981). To be qualifying, the FEV_1 as well as the MVV or FVC values must equal or fall below the applicable table values. *Tischler v. Director, OWCP*, 6 B.L.R. 1-1086 (1984). I must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1- 154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). In assessing the reliability of a study, I may

[8]A "qualifying" pulmonary function study or arterial blood gas study yields values that are equal to or less than the applicable table values found in Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(b)(2)(i) and (ii). A "non-qualifying" test produces results that exceed the table values.

accord greater weight to the opinion of a physician who reviewed the tracings. *Street v. Consolidation Coal Co.*, 7 B.L.R. 1-65 (1984). Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984). If a study is accompanied by three tracings, then I may presume that the study conforms unless the party challenging conformance submits a medical opinion in support thereof. *Inman v. Peabody Coal Co.*, 6 B.L.R. 1-1249 (1984). Also, little or no weight may be accorded to a ventilatory study where the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984); *Justice v. Jewell Ridge Coal Co.*, 3 B.L.R. 1-547 (1981).

Drs. Dahhan and Hippensteel reported that Claimant exhibited poor cooperation during their respective pulmonary function tests. I find Claimant's poor cooperation on the tests make the results inherently unreliable, and I shall not consider them or grant them probative weight. *See Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984).

The remaining pulmonary function test – Dr. Rasmussen's May 8, 2001 test -- failed to produce qualifying values.

All blood gas study evidence of record must be weighed. *Sturnick v. Consolidation Coal Co.*, 2 B.L.R. 1-972 (1980). This includes testing conducted before and after exercise. *Coen v. Director, OWCP*, 7 B.L.R. 1-30 (1984); *Lesser v. C.F. & I. Steel Corp.*, 3 B.L.R. 1-63 (1981). In order to render a blood gas study unreliable, the party must submit a medical opinion that a condition suffered by the miner, or circumstances surrounding the testing, affected the results of the study and, therefore, rendered it unreliable. *Vivian v. Director, OWCP*, 7 B.L.R. 1-360 (1984) (miner suffered from several blood diseases); *Cardwell v. Circle B Coal Co.*, 6 B.L.R. 1-788 (1984) (miner was intoxicated). Similarly, in *Big Horn Coal Co. v. Director, OWCP [Alley]*, 897 F.2d 1045 (10th Cir. 1990) and *Twin Pines Coal Co. v. U.S. DOL*, 854 F.2d 1212 (10th Cir. 1988), the court held that the administrative law judge must consider a physician's report which addresses the reliability and probative value of testing wherein he or she attributes qualifying results to non- respiratory factors such as age, altitude, or obesity.

The record contains four arterial blood gas studies. The reports indicate no contradiction of the regulatory quality standards, and I accord each blood gas probative weight on the issue of total disability. Only Claimant's May 8, 2001 resting arterial blood gas study produced qualifying values. Thus, the preponderance of the arterial blood gas study evidence weighs against a finding of total disability.

Section 718.204(b)(2)(iii) provides that a claimant may prove total disability through evidence establishing cor pulmonale with right-sided congestive heart failure. This section is inapplicable to this claim because the record contains no such evidence.

Where a claimant cannot establish total disability under subparagraphs (b)(2)(i), (ii), or (iii), Section 718.204(b)(2)(iv) provides another means to prove total disability. Under this section, total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a respiratory or pulmonary impairment prevents the miner from engaging in his usual coal mine work or comparable and gainful work.

The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 BLR 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms and patient's history. *See Hoffman v. B & G Construction Co.*, 8 BLR 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 BLR 1-295 (1984); *Buffalo v. Director*, OWCP, 6 BLR 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp*., 2 BLR 1-130 (1979). A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for this Court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc).

The record contains four physicians' opinions addressing Claimant's pulmonary impairment. Each opinion will be discussed and weighed individually.

Dr. Dahhan does not ascribe a specific level of pulmonary impairment to Claimant, but he concludes that Claimant is unable, from a respiratory standpoint, to return to his usual coal mine employment or comparably physical labor due to Claimant's chronic obstructive airways disease and sleep apnea. I accord Dr. Dahhan's opinion less than full probative weight because the doctor's opinion is devoid of any indication of the actual level of impairment suffered by Claimant. While I grant the doctor's opinion that Claimant cannot return to his usual coal mine employment some deference, in my effort to establish the actual level of impairment suffered by Claimant, Dr. Dahhan's opinion offers marginal guidance.

Dr. Rasmussen also opined that Claimant was unable, from a respiratory standpoint, to return to his usual coal mine employment. Unlike Dr. Dahhan, Dr. Rasmussen ascribed to Claimant a "moderate" respiratory impairment because of "at least [a] minimal loss of lung function" which prevented Claimant, according to the doctor, from performing heavy manual labor. I find the doctor's report well reasoned and well documented. The report includes an extremely thorough patient history and copious examination observations. Furthermore, the doctor's finding of a loss of lung function is supported by the objective respiratory test results reported in the opinion. Accordingly, I grant the opinion probative weight.

Dr. Hippensteel opined that Claimant suffered from "no more than" a mild obstructive pulmonary impairment. While he concluded that Claimant could not return to his usual coal mine employment from a whole-body physical standpoint, he concluded that, from a respiratory standpoint, Claimant could return to his usual coal mine employment. I find the probative value of Dr. Hippensteel's opinion to be questionable. At certain points, the doctor's opinion draws more attention to what it does not say, rather than what it does provide the reader. In his physical examination, the doctor observes "minimal, scattered bilateral[]" wheezes and "reasonably good" air movement, but the doctor never addresses these observations in his diagnosis section. I interpret his comments to mean some wheezing was detected along with air movement that is "reasonably good" but not very good or excellent, i.e. less that what a reasonable patient would desire for himself or herself. These observations would appear to be material to a diagnosis of lung health and function, and the doctor's omission of them from discussion renders his opinion less probative. Secondly, Dr. Hippensteel appears to guess the result of an exercise portion of an arterial blood gas study when he states

> Although no exercise arterial blood gas measurement could be obtained, his normal diffusion and normal alveolar/arterial oxygen gradient *would make for an expectation* that he would not have deterioration of gas exchange with exercise referable to any lung disease.

(EX 12)(emphasis added). The doctor's exercise study of Claimant was actually stopped due to dyspnea and back and leg pain, and he never explains to what extent his diagnosis is formed by his "expectation" of certain results. Furthermore, despite not finishing the arterial blood gas study, Dr. Hippensteel concludes that Claimant's dyspnea is nonpulmonary in origin because "[d]yspnea *can* result from nonpulmonary problems." (EX 12)(emphasis added). I grant less weight to Dr. Hippensteel's opinion because I find it poorly reasoned. Dr. Hippensteel appears to fill in blanks in his own data without sufficiently considering pulmonary origins for the impairments he identified. Thus, I find his opinion less probative.

Dr. Abad opined that Claimant was totally disabled from his usual coal mine employment due to "persistent bronchospasms & hypoxemia." I grant little probative weight to the doctor's opinion, however. No documentation is attached to the report, and the existence of a physical examination is only implicit. Furthermore, the doctor' rationale is communicated by handwriting that is barely legible, and my finding that the doctor attributed Claimant's impairment to "persistent bronchospasms & hypoxemia" is only my best guess of what the poor handwriting actually stands for. For these reasons, I grant the doctor's opinion less probative weight.

I find the narrative opinions demonstrate a moderate respiratory impairment. I conclude that the opinions prove a *moderate* impairment for two primary reasons. First, Dr. Rasmussen's opinion is the most probative impairment opinion of record, and to his opinion I accord the most weight. Secondly, each opinion of record is supportive, at minimum, of a minimal impairment

given that Dr. Hippensteel found a *mild* impairment, Dr. Rasmussen found a *moderate* impairment, and the opinions of Drs. Abad and Dahhan are supportive of *at least* a *minimal* impairment.[9]

In assessing total disability under § 718.204(b)(2)(iv), the administrative law judge, as the fact-finder, is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Budash v. Bethlehem Mines Corp.*, 9 B.L.R. 1-48, 1-51 (holding medical report need only describe either severity of impairment or physical effects imposed by claimant's respiratory impairment sufficiently for administrative law judge to infer that claimant is totally disabled). Once it is demonstrated that the miner is unable to perform his or her usual coal mine work, a prima facie finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(c)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

I have previously determined that Claimant's usual coal mine employment required moderate to heavy manual labor. I find that Claimant's moderate respiratory impairment prevents him from performing his usual coal mine employment or comparable physical labor. Claimant worked in a demanding, harsh, extremely dusty underground environment that required constant standing, pushing, pulling, lifting, and stooping during ten hour shifts. The type of work performed by Claimant is not easy, nor does it allow for physical limitations. The narrative medical evidence establishes that Claimant suffered from more than simply a minor breathing problem. Rather, Claimant experiences significant dyspnea upon minimal exertion. He becomes short of breath, and objective testing has confirmed some level of respiratory impairment according to every physician of record. In total, the narrative evidence paints a picture of a coal miner who does not possess the respiratory ability to perform his usual coal mine employment. Accordingly, I find the narrative evidence supports the conclusion that Claimant is totally disabled.

When I consider all of the evidence addressing total disability, I find the preponderance of the evidence establishes total disability. Weighing against total disability are Claimant's lone valid pulmonary function test, three arterial blood gas studies, and Dr. Hippensteel's opinion. Weighing in favor of total disability are the narrative opinions of Drs. Dahhan, Rasmussen, and Abad, and one arterial blood gas study. For the following reasons, I find the preponderance of the evidence rests with the latter.

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[9] Drs. Dahhan and Abad offer no specific level of impairment, but both concluded that Claimant was totally disabled. Thus, the opinions of Drs. Dahhan and Abad must, at least, be supportive of a finding of a minimal pulmonary impairment, if not more, because a miner must at least have a minimal impairment to be found totally disabled.

First, although the May 8, 2001 pulmonary function test did not produce qualifying values, Dr. Rasmussen opined that Claimant's results demonstrated a minimal obstructive ventilatory impact and a reduced maximum breathing capacity. Thus, while not technically proving total disability itself, the test results indicate some level of impairment.

Second, Dr. Rasmussen's report is the best documented, best reasoned piece of medical evidence in the record. The doctor's thoroughness and specificity render his report especially probative, and, I accord additional weight to his determination that Claimant is totally disabled.

Furthermore, Dr. Hippensteel's opinion is rendered less probative by its numerous analytical omissions.

Finally, I accord more weight to the narrative examination reports than the single objective pulmonary tests. The doctor's reports are more comprehensive and thus provide a better picture of the miner's overall respiratory health and function.

When I consider the evidence as a whole, I find Claimant has established total disability by a preponderance of the evidence.

Finally, claimant must also establish that his total disability is due to pneumoconiosis. 20 C.F.R. § 718.204(c). Section 718.204(c) contains a standard for determining whether total disability is caused by the miner's pneumoconiosis and provides the following:

> (1) *Total disability due to pneumoconiosis defined.* A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis...is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:
>
> > (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
> >
> > (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. § 718.204(c).

The instant record contains four narrative opinions. With respect to the use of blood gas studies and pulmonary function tests, "the Board consistently has held that pulmonary function studies and blood gas studies are not diagnostic of the etiology of the respiratory impairment, but are diagnostic only of the severity of the impairment." *Tucker v. Director,* OWCP, 10 B.L.R. 1-35, 1-41 (1987). Thus, only the narrative opinions of record are relevant to this inquiry.

In reviewing the medical opinion evidence regarding etiology, I accord those opinions wherein the physicians did not diagnose the miner as suffering from pneumoconiosis little probative value. *See Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995)(holding medical opinion wherein miner is determined not to suffer from pneumoconiosis or is not totally disabled can carry little weight in assessing etiology of the miner's total disability); *Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819 (4th Cir. 1995). Three of the four narrative opinions concluded that Claimant suffers from legal pneumoconiosis and is totally disabled. Only Dr. Hippensteel did not diagnose pneumoconiosis. Accordingly, I grant his opinion little weight on the issue of whether pneumoconiosis contributed to Claimant's total disability.

Likewise, I grant little probative weight to Dr. Abad's opinion. The doctor's report is not documented, and he provides no rationale for his opinion. Accordingly, the report is of little probative value.

The remaining opinions belong to Dr. Rasmussen and Dahhan. Dr. Dahhan opined that Claimant's total disability was attributable to Claimant's lengthy smoking habit based on Claimant's elevated carboxyhemoglobin level and Claimant's obesity induced sleep apnea. Dr. Dahhan stated that coal dust inhalation did not cause Claimant's total disability, but he did not explain how he arrived at that conclusion. Dr. Rasmussen attributed Claimant's pulmonary impairment to coal dust inhalation and cigarette smoking, but he failed to offer an explanation for his conclusions. Both opinions suffer from inadequate reasoning. Neither doctor provides guidance to the court demonstrating how he arrived at his conclusions. Rather, the doctors' opinions on causation seem to be summarily proffered at best. Accordingly, I grant neither doctor's opinion controlling probative weight.

I find Claimant has failed to establish that his pneumoconiosis is a substantially contributing cause in his total disability. While a preponderance of the causation evidence establishes that his smoking was a substantially contributing cause, there is no such preponderance concerning his pneumoconiosis as a causal factor.

Conclusion

In sum, the evidence establishes the existence of pneumoconiosis and a totally disabling respiratory impairment, but it does not establish that his total disability was due to pneumoconiosis. Accordingly, the claim of Larry S. Boggs must be denied.

Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to claimant for legal services rendered in pursuit of the claim.

ORDER

The claim of Larry S. Boggs for benefits under the Act is denied.

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JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty days from the date of this decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington D.C. 20013-7601. This decision shall be final thirty days after the filing of this decision with the district director unless appeal proceedings are instituted. 20 C.F.R. § 725.479. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.